SCHOOL: _____

PP

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Manchester Health Department
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Manchester, NH 03101
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School Name: _____
Grade: _____
School Fax: _____

STUDENT HEALTH HISTORY

1. Name (Full Legal): _____ 2. D.O.B: ____/____/____ 3. Child's Sex: ___M ___F
   First M Last Month Day Year
4. Home Address: _____ Home Tel. #_____ 5. Place of Birth:_____
6. Child's Race/Ethnicity:
   ___ White, non Latino / non Hispanic ___ African American or Black ___ Asian American or Pacific Islander
   ___ American Indian, Eskimo ___ Latino/Hispanic Origin ___ Other_____
7. Primary Language spoken at home: _____ Is English understood at home? ___ Yes ___ No
8. Has your child had any previous schooling? ____ Yes ___ No If yes, where? _____ How long? _____
9. Name of Parent(s)/Guardian(s): _____
10. Mother/guardian's Occupation: _____
11. Father/guardian's Occupation: _____
12. Does your child have a physician or primary care provider? ____ Yes ____ No If no, date of referral _____ ☐
    If yes, name of child's physician / PCP_____ Tel #: _____
    (Name of Primary Care Provider)
13. What kind of place does your child's physician work out of?
    ___ Clinic (Name of clinic)_____
    ___ Doctor's Office _____
    ___ Emergency Room (Name of Hospital) _____
    ___ Some other place: (Name) _____
14. When was the last time your child received a well-child check-up (that is a general check-up when he/she were not sick or injured)?
    _____ Never _____
15. Was there a time during the past year that your child needed health care but was unable to get it? _____ Yes _____ No
16. Child's Health Insurance: If none, date of referral _____ ☐
    ___ My child does not have health insurance ___ Private /HMO (Name of health insurance: _____
    ___ Healthy Kids Gold/Medicaid
    ___ Healthy Kids Silver _____ Other: _____
17. Does your child have a dentist? ____ Yes ____ No If no, date of referral _____ ☐
    If yes, name of child's dentist: _____ Tel #_____
    Does your child have dental insurance? _____ Yes ___ No
18. How long has it been since your child saw a dentist (this includes a visit with an orthodontist, oral surgeon, other dental specialist, dental hygienist)?
    ____ My child has never seen a dentist
    ____ More than 6 months but less than 1 year
    ____ More than 1 year but not more than 2 years
    ____ Six months or less
    ____ More than two years

Pregnancy & Birth

19. Did you have any health problems during your pregnancy? ___ Yes ___ No
20. Were there any complications in the child's birth or delivery? ___ Yes ___ No
21. What were the complications?
    ___ Prematurity
    ___ Anoxia (baby didn't get enough oxygen)
    ___ Eclampsia/pre-eclampsia (mother's high blood pressure) / toxemia (swelling)
    ___ Cesarean section
    ___ Respiratory distress syndrome
    ___ Meconium (baby's fecal matter excreted at or near birth)
    ___ Fetal distress
    ___ Breech / malpresentation (baby's feet came out first)
    ___ Premature rupture of membrane
    ___ Dysfunctional labor
    ___ Other: Please specify _____
22. Was the baby born:
    ____ When expected ____ Earlier ____ Later?

-Over-

Pregnancy & Birth (con't)

23. What was your child's birth weight?
____ pounds ____ ounces

24. Was the child a twin, triplet, or other multiple birth?
___ No ___ Yes, a triplet
___ Yes, a twin ___ Yes, four or more
___ Don't know

25. Was your baby sick during the first 3 months of life?
___ Yes ___ No
If yes, please explain: _____

GENERAL HEALTH & HEALTH CARE

26. In general, would you say your child's health is:
___ Excellent ___ Very good ___Good
___ Fair ___ Poor

27. Has a physician or health care provider ever told you that your child had any of the following?
___ Diabetes
___ Asthma
___ Congenital heart disease
___ Down's syndrome
___ Cerebral palsy
___ Attention deficit hyperactivity disorder (ADD or ADHD)
___ Mental retardation
___ Learning disability
___ Other developmental delays
___ Sickle cell anemia
___ Other: _____

28. During the past 12 months has your child had any of the following conditions?
___ Any kind of respiratory infection
___ Any kind of respiratory allergy
___ Any kind of food or digestive allergy
___ Seizures
___ Anemia
___ Eczema or skin allergy
___ Stuttering or stammering
___ Three or more ear infections
___ Frequent or repeated diarrhea or colitis
___ Frequent or severe headaches, including migraines

29. Is your child taking ANY medication? ___ Yes ___ No
Name of medication(s) _____

30. During the past 12 months how many times has your child seen a health care provider or nurse for any sickness or injury? _____ (approximate number of times)

31. Would you say your child behaves and relates to other children and adults?
___ Better than other children his/her age
___ As well as other children
___ Slightly less well than other children
___ Much less well than other children

32. Has your child's behavior ever been assessed?
___Yes ___ No

If yes please explain: _____

Parent / Guardian Signature Date

Eyes, Ears, Nose & Throat

33. Does your child have any of the following?
___ Problems with eyes
___ Eyes turn in or out when tired
___ Wears glasses
___ Hearing loss
___ Wears hearing aids
___ Frequent nosebleeds

34. Did your child ever have any of the following?
___ Three or more ear infections during the first 3 years of life
___ Tubes in his/her ears
___ Strep throat two or more times in a year

Skin / Allergies

35. Does your child have any of the following?
___ Problems with rashes
___ Allergies or reactions to medicines or injections
___ Allergy or reaction to bee sting or insect bites
___ Allergy to food / dyes
If yes, please explain: _____
Does your child have medication for it? ___ Yes ___ No
Name of medication(s) _____

Gastrointestinal

36. Does your child have any of the following?
___ Poor appetite
___ Excessive thirst
___ Frequent stomachaches
___ Frequent diarrhea
___ Trouble with constipation
___ Problem with kidneys
___ Problem with urine
___ Bladder or bowel control day or night

If yes, please explain_____

Other Problems and Illnesses

37. Has your child ever had any of the following?
___ Chicken pox. Date of disease _____
___ Serious accidents or injuries
___ Broken bones
___ A hospitalization overnight, other than birth
___ Special tests for health problems
___ Appointment with a specialist during the past year

If yes, please explain: _____

38. Does your child...
___ Tire easily
___ Seem to be overly active
___ Have any physical restrictions
___ Have any heart problems

If yes, please explain _____

39. Has your child lived in a house built before 1950 that had peeling paint? ___ Yes ___ No
___ Has your child ever been tested for lead poisoning?
___ Has your child ever been *treated* for lead poisoning?

If yes, please explain: _____

Reviewed by (School Nurse) Date